

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/15/2010
NAME OF PROVIDER OR SUPPLIER CHURCH HILL CARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 701 WEST MAIN BLVD CHURCH HILL, TN 37642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>An onsite visit was conducted on July 14, 2010, to investigate complaint # 26269, at Church Hill Care and Rehabilitation Center. No deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</p>		N 002		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

KJ2Q11

If continuation sheet 1 of 1